STATE OF ALABAMA
DEPARTMENT OF FINANCE
DIVISION OF RISK MANAGEMENT
STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

ACCIDENT REPORT - EMPLOYEE'S STATEMENT

This form to be completed by the employee and submitted to immediate supervisor on the day the injury occurred. The supervisor should fax the First Report of Injury (SEICTF Form 1) along with this form immediately to:
FAX (334) 223-6170 or toll-free: (888) 827-6753.

Name of Employee: _____ Social Security Number _____
Home Address: _____
Home Phone No.: _____ Employee's Date of Birth: _____
Job Title: _____ County of Employment: _____
Date of Injury/Accident: _____ Time of Injury/Accident: _____ a.m. p m.
Date Supervisor Notified: _____
Was accident / injury the result of an automobile accident? _____ Yes _____ No
If yes, obtain a copy of police report of accident and submit to supervisor as soon as possible.

City or Town where injury/accident occurred: _____
Location or place where accident/injury occurred: _____
Were there any witnesses? If so, give names, addresses, and phone numbers. _____
_____
_____

Describe fully what happened to cause the injury/accident and indicate the body part(s) affected:
_____
_____
_____
_____
_____
_____
_____

At the time of the injury where you using any protective equipment (ex. latex gloves, eye protection)? _____ Yes _____ No If yes, list what equipment was being used:
_____

Insurance Coverage? _____ Yes _____ No If yes, Blue Cross (State of Alabama) _____
Other _____

Signature of Employee: _____ Date: _____

Signature of supervisor reporting incident: _____ Date received: _____